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# THE GENERAL PRACTITIONER: POWERFUL ALLY GAINST MENTAL ILLNESS

TESTIMONY BEFORE

HOUSE APPROPRIATIONS SUBCOMMITTEE ON LABOR-H.E.W. HEARINGS

ON FISCAL 1958 BUDGET (REP. JOHN FOGARTY, CHAIRMAN)

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BY

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Mr. Chairman and members of the Committee:

The general practitioner is the first line of defense in the community against the initial onset of mental illness. However, up until very recently he has isolated himself from psychiatry, and psychiatry has isolated itself from him. Most of the family physicians practicing today have had little or no training in psychiatry, since medical schools ignored the subject in their curricula. Because the mental hospital system was out in the woods and isolated from the main stream of American medicine, the family physician felt no responsibility for the care of mental patients. As a matter of fact, he frequently refused to visit a distant mental hospital to treat patients.

With the advent of the new tranquilizing drugs, the situation has changed dramatically. The family physician today is probably prescribing more medication for disturbed individuals than is the psychiatrist.

This is a natural development. Dr. Francis Braceland, President of the American Psychiatric Association, pointed out recently that "the key preventive agent in the entire mental effort may well be the physician in community practice, for the physician in general practice sees every segment of the population, every age group, and persons at all economic and social levels....In his care of expectant mothers, in his obstetric work, in his care of babies and children, he may accomplish preventive

psychiatry of heroic proportions."

Echoing the Braceland theme, Drs. Fred W. Langner and Robert L. Garrard of North Carolina gave it added emphasis in a paper delivered earlier this year before the Tri-State Medical Society.

"Psychiatry offers many useful tools with which to ameliorate this situation, but it lacks the manpower to implement them adequately," they contended." ...The general practitioner enjoys several strategic opportunities not shared by the psychiatrist. First, because of his closeness and position of confidence with the families in his community. ...Second, in the treatment of emotional disorders he maintains a position of advantage over the psychiatrist in two significant areas: he is more intimately acquainted with the patient's total environment and he sees the patient earlier in the development of the illness...The general practitioner has another great advantage in working with emotional illness in that he is more apt to talk the language of the patient and relatives. He usually knows the entire family and is able to ease anxiety and tension in other members who are threatened."

The North Carolina doctors concluded with a plea for increased use of this great medical reservoir:

"...Psychiatry is moving out of the mental hospitals and into the community, and the general practitioner will practice more and more psychiatry. The most powerful and frequently used drug in general practice is the doctor himself. None of the miracle drugs can hope to prove more powerful than the inter-personal relationship between the doctor and the patient. This still remains the greatest single tool of psychiatry and one which is available to every physician. The wise family doctor knew this to be true before the word psychiatry was devised."

This raises several serious problems. First of all, the general practitioner must receive some post-graduate training in the handling of emotional illnesses. He must know much more about the diagnosis of the various mental illnesses, and he must learn the difficult art of proper referral to a psychiatrist.

contributed by states and localities. However, during 1956 the states and localities spent approximately $25 million for the support of community mental health services as against the $4 million contributed by the Federal government.

Looked at in the light of other Federal expenditures for training, the proposed sum is a very small one indeed. The Air Force recently estimated that it costs about $620,000 to train a B-47 bomber pilot. The cost of the general practitioner program, then, would roughly equal the cost of training two B-47 pilots.

Since the time at my disposal is short, I would like to devote the remainder of my testimony to an explanation of the budget proposals for the training of the general practitioner.

The following areas of support, but not the specific budget proposals, are adapted from a series of special recommendations developed at a joint meeting of the Ad Hoc Committees of the American Psychiatric Association and the American Academy of General Practice:

1. Mental health fellowships for general physicians to provide three months of intensive training in established psychiatric centers.

Stipends to 100 general practitioners at $1,800 each - $180,000

Grants to teaching centers for additional faculty, etc. 100,000

Total Mental Health Fellowship Program $280,000

Explanation: During World War II the Armed Services, faced with a critical shortage of psychiatrists, developed a 90-day training course for the training of general practitioners and other MD's in limited psychiatric skills. Many doctors have testified that this training has been invaluable in their present day handling of the emotional problems of patients. The proposed item would revive this highly important program, since we are still faced with a critical shortage of psychiatrists.

2. Stipends to enable General Practitioners to take the required three-year Residency

leading to certification as Psychiatrists:

Average Stipend - $4,200 a year. For 100 general practitioners, $420,000.

Explanation: Dr. Daniel Blain, Medical Director of the American Psychiatric Association, has estimated that it will take 20 years to double the present number of psychiatrists, but we need, according to A.P.A. standards, twice that number right now.

The basic pool of prospective psychiatric residents is limited totally to medical school graduates; the M.D. degree is a pre-requisite to specialization in psychiatry. Even if the medical schools are able to increase appreciably their enrollments, these gains will be nullified by the rapid increase in our population.

So we must widen the basic pool from which we draw psychiatrists. In doing this, we have the invaluable experience of the Veterans Administration to guide us. In 1950, the Korean War and the Doctor Draft cut deeply into the medical school graduate pool available for psychiatric residency training in the V. A.

The V.A., faced with the stark alternative of cutting its psychiatric services to sick veterans to the kind of minimal level which precipitated a national furor in 1945, took the bold step of developing a program designed to recruit the general practitioner into psychiatry. It knew that many general practitioners, particularly those who had been exposed to psychiatry during World War II, wanted to go into that speciality. However, these doctors were no longer youngsters. They had completed lengthy service in the Armed Forces, they had families and mortgages, and they couldn't afford to start in as residents at the prevailing stipend of approximately $300 a month.

The V.A. therefore developed its famous Career Residency program. Under this program, general practitioners were given credit for the number of years they had practiced medicine in the community, up to a maximum of six years. The majority of family physicians who came into the V.A. program received the full six years of credit and they started their residency at a stipend level of approximately

$9,000 a year, the equivalent of a beginning staff salary. In other words, the V.A. picked up the tab for the difference between the regular residency stipend and the stipend for the general practitioner. In return, the career resident agreed to serve a minimum of two years in a V.A. hospital upon completion of his training.

The Career Residency program is now in its fifth year, and it has been pronounced a resounding success by psychiatric authorities. Proof that it has widened the pool of available psychiatrists is the fact that more than half of the Career Residents have had at least six years of prior experience as general practitioners, and 89 percent of them are more than 30 years of age. Currently, more than 50 percent of the psychiatric residents in the V.A. hospital system are former general practitioners. Thousands of mentally ill veterans are receiving high quality psychiatric care today because of this program.

If we can develop such a program for the veteran, why can't we do it for the rest of the American people? Under the National Mental Health Committee proposal, 100 general practitioners who wanted to become psychiatrists would apply to the National Institute of Mental Health for Career Fellowships. Since the NIMH already awards a considerable number of advanced training stipends in the various psychiatric disciplines, it has developed the basic mechanisms for this type of program. Under the plan, it is suggested that stipends would be granted on the following basis:

General practitioner with two years experience - $3,600 a year.

General practitioner with four years experience - $4,200 a year.

General practitioner with six years experience - $4,800 a year.

The average stipend would probably be $4,200 a year.

As in the Veterans Administration program, this Career Stipend would be added to the regular residency stipend which the general practitioner would receive from the institution giving him the training. For example, if the training institution paid him $3,600 a year, the average stipend under the Career program would bring this up to $7,800 a year. While not a princely sum, it would probably keep the general

practitioner and his family close to the black side of the ledger.

How would the country benefit from this kind of program? First of all, a direct benefit would come from the provision that a general practitioner so trained would be required to devote at least two years - possibly three - to work in a public psychiatric facility. This facility could be a mental hospital, a community mental health clinic, a psychiatric unit in a general hospital, etc.

But beyond this period of required service, the major gain would be enormous. the greatest single bottle-neck to progress in the fight against mental illness is the shortage of trained psychiatrists. For example, this Committee has been most generous in its appropriations for the support of psychiatric research. As we accumulate new therapies to treat mental illness, we are faced with the cruel dilemma of not having enough psychiatrists to apply this newly found knowledge to the mentally ill of our nation. To quote Dr. Blain again:

"The problems of personnel shortages in psychiatric services are so overwhelming, so well known and so frustrating that they seem to threaten the very possibility of progress. For lack of manpower, whole programs lie in abeyance; facilities are hopelessly over-taxed, and some are closed to new admissions. Waiting lists are static. Key positions in our field, such as Commissionerships in the States, Superintendencies of Mental Hospitals, Directorships of psychiatric clinics, stand vacant for months and even years."

3. Pilot Projects in the Training of the General Practitioner - $500,000

The National Mental Health Committee proposes that ten experimental projects in the training of the general practitioner be supported at a level of about $50,000 each.

Explanation: When we talk about the training of the general practitioner in psychiatric skills, we venture into an area where little is known and a great deal must be learned. In the scores of letters I have received from national and state officials of the American Academy of General Practice over the past year, there have been innumerable suggestions as to what the general practitioner expects in the way of

training in psychiatric skills. Here are just a few of the suggestions:

a. The proper diagnosis of the various psychiatric ailments encountered by the general practitioner in his daily practice.

b. Information on the types of patients who can be handled satisfactorily by the family doctor in his own office.

c. What patients must of necessity be referred to a psychiatrist and what are the effective techniques of referral.

d. The proper use of the tranquilizing drugs, including information on what types of patients they should be given to. Also basic data on proper dosages, the handling of side effects, etc.

e. The role of the family physician in caring for patients discharged to the community from mental hospitals. For example, in a rural area where there are no psychiatrists, how can the family physician be equipped to treat mental patients who otherwise might lapse back into the mental hospital?

How impart these skills to the family physician? Again, there are innumerable suggestions as to the best training procedures. Dr. D. W. McKinlay, the chairman of the Commission on Education of the American Academy of General Practice, writes me "that to accomplish something real, post-graduate courses of at least a week or more should be made available on a very wide and continuing basis." Dr. Jesse D. Rising of Kansas City, also a member of the Commission on Education, suggests "grants of money to medical schools for the purpose of securing top notch teachers for programs which will be attended by general physicians, both general practitioners and internists, and probably many others." Dr. John S. De Tar of Michigan, the distinguished president of the American Academy of General Practice, stresses the point that "the postgraduate medical education of the family physician must include a great deal of educational material on the subject of mental illness." A number of officers of State Academies of General Practice inform me that most family physicians are too busy caring for the sick to take a week or two out of their

practice; they suggest an hour or two a week of instruction over a long period.

It will be valuable to explore many of these approaches during the next few years. For that reason, the National Mental Health Committee suggests the following as just a few of the training projects which might be set up:

a. A training course for general practitioners conducted over a period of at least one week. This should probably be undertaken by a department of psychiatry in a medical school, with the full cooperation of the State Academy of General practice.

b. A three-day post-graduate training course conducted at one of the large public mental hospitals, federal or state. The hospital selected would have to be one with an unusually fine staff.

c. A training course conducted by a State Academy of General Practice. A number of state academies have recently formed committees on mental health, and these committees could be given the responsibility for the training courses. It will be necessary for these committees to pay psychiatric faculty recruited for the training programs.

d. A pilot training program conducted in a community mental health clinic. A mental health clinic, which frequently treats hundreds of patients on an out-patient basis in the course of a year, is an ideal training ground for the general practitioner. At such a clinic, he will encounter most of the problems which he is likely to see in his practice of family medicine. Upon completion of such training, he can be an invaluable ally in the treatment program of the clinic.

e. A pilot program using the general practitioner in the followup of discharged patients from mental hospitals. More than 250,000 patients are discharged each year from our state mental hospitals alone, yet the great majority of them are not followed up in the community. In a pilot project of this kind, the mental health committee of either the State Academy of General Practice or the State Medical Association would be the organizing body. It would draw up a list of all general practitioners willing to

undertake treatment and counselling of mental patients discharged into the various communities. Mental Hospitals would turn over to these physicians all data on treatment received by the patients while institutionalized, and the physicians, in turn, would keep the hospitals informed on subsequent progress of the patients while treated in the community. A recent limited experiment along these lines has been started by the mental health committee of the Washington State Medical Association.

4. Appropriation to the National Institute of Mental Health - $100,000

In the education of the general practitioner, the National Institute of Mental Health must play a leading role. Its major contribution would be the development of suitable training materials for the various training courses designed for the general practitioner. These would include suggested course outlines, training films, newsletters, etc. In addition, the Institute should be charged with the responsibility of developing statistical data on the role of the general practitioner in mental illness. This should include material on the amount of emotional illness seen by the family physician, drug usage, referrals to a psychiatrist, etc.

## NATIONAL INSTITUTE OF MENTAL HEALTH

| | FISCAL 1957 APPROPRIATION | FISCAL 1958 ADMINISTRATION ESTIMATE | CITIZENS REQUEST |
|---|---|---|---|
| GRANTS | | | |
| Research grants | 11,426,000 | 10,902,000 | 10,902,000 |
| Research fellowships | 647,000 | 647,000 | 647,000 |
| Training grants | 12,000,000 | 12,000,000 | 13,200,000 (1) |
| Grants for detection, diagnosis, and other preventive & control services | 4,000,000 | 4,000,000 | 4,000,000 |
| DIRECT OPERATIONS | | | |
| Research | 4,940,000 | 5,324,000 | 5,324,000 |
| Review & approval of grants | 502,000 | 541,000 | 541,000 |
| Training activities | 101,000 | 78,000 | 178,000 (2) |
| Professional & technical assistance | 1,227,000 | 1,273,000 | 1,273,000 |
| Administration | 354,000 | 452,000 | 452,000 |
| T O T A L | 35,197,000 | 35,217,000 | 36,517,000 |

(1) Includes $1,200,000 in grants for the training of the general practitioner.

(2) Includes $100,000 for educational materials in the training of the general practitioner.